No. 90-8466

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

DAVID E. RIGGINS,

Petitioner,

v.

STATE OF NEVADA,

Respondent.

ON WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF NEVADA

BRIEF *AMICUS CURIAE* OF THE COALITION FOR THE FUNDAMENTAL RIGHTS OF EQUALITY OF EX-PATIENTS IN SUPPORT OF PETITIONER AND FOR REVERSAL OF THE JUDGMENT BELOW

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QUESTION PRESENTED FOR REVIEW

Whether forced medication at trial of a defendant who has asserted the insanity defense in a capital case violates his right to a full and fair trial under the Sixth and Fourteenth Amendments to the United States Constitution.

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I.

STATEMENT OF INTEREST OF AMICUS CURIAE

This brief *amicus curiae* is being filed in support of the Petitioner and his arguments against his drugging at trial and for reversal of the judgment below. This case is of paramount concern to all of the organizations participating in the advocacy of *amicus curiae*, the Coalition for the Fundamental Rights and Equality of Ex-patients ("The Coalition for the Free").[1] Since the issue of involuntary use

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1. The participants in the Coalition for the FREE are as follows:

The NATIONAL MENTAL HEALTH ASSOCIATION ("NMHA") is the nation's oldest and largest non-governmental, citizens' voluntary organization concerned with mental illnesses and mental health. Founded in 1909 by Clifford Beers, a man who suffered from a serious mental illness, the NMHA has historically led efforts on behalf of mentally ill people in institutions and the community. The NMHA has grown into a network of 650 chapters and

of psychotropic drugs first emerged, the Coalition and many of its

state divisions working across the United States. It is composed of volunteers who include family members whose loved ones have been affected by mental illness and former patients. All are committed to advocacy for the improved care and treatment of mentally ill people, the promotion of mental health and the prevention of mental illnesses.

The NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS ("NAPAS") represents agencies established pursuant to the Protection and Advocacy for Mentally Individuals Act of 1986, 42 U.S.C. § 10801, *et seq*. These agencies have the statutory mandate to protect and advocate the rights of persons identified as mentally ill.

PENNSYLVANIA PROTECTION AND ADVOCACY, INC. ("PP&A") is the federal protection and advocacy agency in Pennsylvania for persons diagnosed as mentally ill pursuant to 42 U.S.C.A. § 10801 *et seq*. PP&A has represented persons who were being drugged while on trial, including persons raising the insanity defense. PP&A has been *amici* in numerous cases, most recently, *Sullivan* v. *Zebley*, 493 U.S. 521 (1990).

The NEW JERSEY DEPARTMENT OF THE PUBLIC ADVOCATE ("New Jersey Public Advocate"), through its DIVISION OF MENTAL HEALTH ADVOCACY ("DMHA"), is a cabinet-level state agency that has represented psychiatric patients for 17 years in a wide range of matters including civil commitment and medication refusal, pursuant to enabling legislation, N.J.S.A. 52:27E-21 through 27. The New Jersey Public Advocate is the federal protection and advocacy Agency in New Jersey under 42 U.S.C.A. 10801 *et seq*. DMHA represented the plaintiff class in *Rennie* v. *Klein*, 720 F. 2d 266 (3d Cir. 1983), one of the first cases to determine the right of psychiatric patients to refuse psychotropic medication. DMHA has filed numerous *amici* briefs on issues related to patients' rights, mental health advocacy, and the "right to refuse" drugging. *See, e.g.*, brief *amici curiae* in *Ake* v. *Oklahoma*, 470 U.S. 68 (1985) and the proposed brief *amicus curiae* in *Mills* v. *Rogers*, 457 U.S. 291 (1982).

The MENTAL HEALTH CONSUMERS' NATIONAL LEGAL DEFENSE AND EDUCATION PROJECT was organized by consumers in Philadelphia, Pennsylvania in 1988 to provide technical assistance, research and training to mental health consumers and their advocates on legal and policy issues involving mental illness and

members have previously been involved in similar "right to refuse" drugging cases in federal and state courts across the country,[2] as well as in "right to refuse" issues before this Court.[3]

Many of the members of the Coalition's constituent groups are themselves mental health consumers who have had their own experiences with the drug involved here and other similar drugs, including drugging during trial proceedings. Many of the other Coalition members are family members and advocates for persons involved in issues related to forced druggings. Because of the Coalition's long-demonstrated concern about the issues related to forced drugging throughout our society, particularly where an individual who has been diagnosed with mental illness is raising the insanity defense in a capital case, the Coalition has a strong interest in participating as *amicus curiae* in this case.

consumers' rights and to assist consumers with access to the courts, legislatures and agencies on matters affecting their lives as consumers of mental health services.

The MENTAL HEALTH PATIENT'S ASSOCIATION OF NEW JERSEY, established in 1984, is a statewide network of individuals and self-help organizations devoted to the development of self-help and advocacy groups and the protection of the interests and rights of mental health consumers.

The MENTAL PATIENTS' ASSOCIATION OF PHILADELPHIA was formed in 1985 in an effort to organize mental health consumers to oppose all efforts to erode the rights and freedoms of those who have been hospitalized for psychiatric illness and to call for an end to discrimination against the psychiatrically disabled in any form.

2. *See, e.g.*, the briefs *amicus curiae* filed by the Coalition in *Riese* v. *St. Mary's Hosp. & Medical Center*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241 (1987) and by members of the Coalition in *Jones* v. *Gerhardstein*, 114 Wis.2d 710, 416 N.W. 2d 883 (1987) and, previously, the representation of the plaintiff class by the New Jersey Public Advocate throughout the case of *Rennie* v. *Klein*, 720 F. 2d 266 (3d Cir. 1983) (*en banc*)

3. *See, e.g.* the briefs *amicus curiae* of the Coalition and that of the New Jersey Public Advocate, separately, in *Washington* v. *Harper*, 494 U.S. 210 (1990) and, together, in *Perry* v. *Louisiana*, 111 S. Ct. 449 (1990)

II.

SUMMARY OF ARGUMENT

Sedation and suppression of emotion are the known, intended effects of Mellaril, the medication used to drug the Petitioner in this case. These known, intended effects of Mellaril combined with the stress of trial, altered his demeanor and behavior so that he appeared sedated and emotionless. These effects of the forced drugging are precisely the reasons that such drugging of defendants during trial violate their constitutional rights to a fair trial and to confront the witnesses against them under the Sixth Amendment and to due process of law under the Fourteenth Amendment. III. A.

Mellaril and other psychotropics are powerful, intrusive and potentially dangerous drugs which should only be used during trial when proven to be absolutely necessary in order to protect the defendant or others. Here, there was no constitutional justification for continuing the involuntary drugging of Petitioner during trial. III. B.

Forced drugging interfered with the Petitioner's ability to mount an effective defense because the jury was not permitted to see his natural, unmedicated demeanor. III. C.

III.

ARGUMENT

A. Because of Its Known, Intended Effects, Involuntary Drugging During Trial Interfered with Petitioner's Constitutional Right To Confrontation.

1. *The Known, Intended Effects of Mellaril Were to Sedate Petitioner and Deaden His Emotions.*

This case is unusual in that, first and foremost, Petitioner's "right to refuse" claim focuses as much on the well known, intended and clearly predictable effects of the drug involved

here,[4] as on the potentially harmful "side" effects which are usually the focus of such claims.[5] In his Motion to Terminate Administration of Medication, dated June 10, 1988,[6] Mr. Riggins pointedly objected to the very effects for which Mellaril is most noted: sedation and loss of affect or emotion. At trial, he denied that the drug helped him to understand what was happening at the trial. R. 742. Significantly, at trial, Mr. Riggins was receiving the maximum dose of Mellaril, 800 mg.[7]

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4. The effects of Mellaril (generic name thioridazine) are described as follows in the standard drug reference work:

> Mellaril (Thioridazine) is effective in reducing excitement, hypermotility, abnormal initiative, affective tension and agitation through its inhibitory effect on psychomotor functions. *Physicians' Desk Reference* 1951 (45th Ed. 1991) (hereinafter "PDR").

5. *See, e.g. Mills* v. *Rogers*, 457 U.S. 291, 293 n. 1 (1982); *Washington* v. *Harper*, 494 U.S. 210 229 (1990).

6. Record on Appeal (hereinafter "R.") at 52.

7. Because of its documented, dangerous side effects (Part III B below) the highest recommended dose of Mellaril is 800 mg. R. 415, 473 ("Eight hundred a day is — well, that's a pretty high dose"). *See* Lindsay, DeVane, Williams and Wilkins, *Fundamentals for Monitoring Psychoactive Drugs* 377 (1990). ("A ceiling dose of 800 mg has been established to minimize the possibility of pigmentary retinopathy. Thioridazine is notable for a high frequency of cardiac effects"). Despite the testimony before the Court that tolerance develops for such high doses, R.473, it is undisputed in psychopharmacological studies that tolerance does *not* develop for Mellaril and other similar drugs. *See* Goudie & Emmett, *Psycholactive Drugs: Tolerance and Sensitization* 375 (1989) (tolerance is "rarely observed in relation to antipsychotic effects"); Perry, Alexander, & Liskow, *Psychotropic Drug Handbook* 5 (1985) ("Tolerance does not develop to the therapeutic effects of antipsychotics"). Nor is there any pharmacological evidence to support the supposed increase in tolerance to Mellaril due to Petitioner's alleged cocaine use. (R. 473) *See, e.g.* World Health Organization, *Adverse Health Consequences of Cocaine Abuse*, 22 (Aris. ed.) (1987); Spitz & Rosencan, *Cocaine Abuse* 265-266 (1987); Spotts & Shontz, *Cocaine Users* 15-19 (1980).

Riggins' symptoms, which included auditory hallucinations (hearing voices), and diagnosis are those of a classic case of schizophrenia.[8] Given his illness, once the decision was made to drug Petitioner, any competent medical professional could have readily foreseen the sedative effects of the drugging on his demeanor, attention and attitude. R. 419-20, 445-446, 474-75. The sedative effects of Mellaril—even absent the added effects of stress of trial—have long been documented in pharmacological texts. Because of the soporific effects of Mellaril, the PDR cautions patients against participating in activities requiring complete mental alertness such as driving. Prescribers are advised to administer Mellaril cautiously.[9]

Finally, the drug's intended "calming" effects have been described in terms that are particularly relevant here regarding Mr. Riggins' demeanor at trial:

> The hostile patient, unreceptive to previous therapy, became *more quiet, more tolerant and less demanding* . . . . The capacity of Thioridazine to suppress the symptoms of schizophrenia was reflected in the prototype of a *calm, obedient, well-behaved and manageable patient.*[10]

Indeed, in some of the leading comparative studies of common psychotropics, the research has demonstrated Mellaril's particular efficacy in regard to sedation; Mellaril is "most likely to produce

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8. *See* Torrey, *Surviving Schizophrenia* at 2, 6 (1983); *Diagnostic and Statistical Manual of Mental Disorders* (3d ed. rev. 1987) ("DSM-III-R"), at 194 (diagnostic criteria for schizophrenia); Grebb & Cancro, "Schizophrenia: Clinical Features," in *Comprehensive Textbook of Psychiatry* 757, 761 (5th ed. 1989)

9. The PDR notes that Mellaril's basic pharmacological activity is similar to that of other phenothiazines, which researchers have described as having "a high incidence of sedation, orthostatic hypotension and anticholinergic side effects." Mendel, *Treating Schizophrenia* 166 (1989)

10. Leger, "A Four Year Appraisal of Thioridazine," 123 *Am. J. Psych.* 728, 729-730, 732 (1966) (emphasis added).

sedation and postural hypotension . . . In fact, the *marked sedation* often produced by chlorpromazine and *thioridazine* limits the practical dosage . . ."[11] Other leading commentators and researchers have long documented the sedative effects of Mellaril and related drugs.[12]

Morever, Mellaril's sedative properties also interfere with the day-to-day intellectual and cognitive performance of its recipients.[13] This deterioration has been observed with Mellaril and other drugs in its class.[14]

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11. Klein, Gittelman, Quitkin and Rifkin, *Diagnosis and Drug Treatment of Psychiatric Disorders* 149 (1980) (emphasis added).

12. *See*, Gillies and Lader, *Guide to the Use of Psychotropic Drugs* 495 (1986) ("In psychiatry thioridazine is used as: A sedative antipsychotic in schizophrenia . . ."); Iversen & Iversen, *Behavioral Pharmacology* 250 (1975) ("Although the sedative effects of the phenothiazines are their most dramatic behavioral effect, it is doubtful if their antipsychotic actions depends on sedation."); Rosenzweig & Griscom, *Psychopharmacology and Psychotherapy* 127 (1978) ("They all have sedative properties but sedation and antipsychotic action are not related, and in some patients sedation may be an undesirable side effect. . . . [A]ntipsychotic action is unrelated to sedation or anti-anxiety properties. . ."); Carlton, *A Primer of Behavioral Pharmacology* 198 (1983) ("The major secondary effects . . are . . . : 1. Sedative . . .").

13. Thus the Thioridazine [Mellaril] subjects demonstrate a lower level of task knowledge and are less consistent than either of the other drug groups [Haloperidol (Haldol) and Trifluoperazine (Stelazine)]. The cumulative effects of these deficiencies result in their overall performance impairment . . . Thioridazine patients, however, actually evidenced deterioration in performance after feedback had been provided in two of three experimental tasks. Gillis, "The Effects of Selected Antipsychotic Drugs on Human Judgment," 21 *Current Therapeutic Research* 224, 231 (1977)

14. "The apparent loss of behavioral response with phenothiazines, therefore, seems to be due to a loss of response to certain controlling stimuli in the environment." Iversen & Iversen, *Behavioral Pharmacology* 248 (1975).

Clearly then, drugging with such a powerful sedative affected—and was affected by—the Petitioner's ability to deal with the stressful interactions inherent in a trial situation, especially a capital trial. The research demonstrates that the effects of psychotropic drugging are, in turn, affected by the environment in which the drugging occurs, and are particularly affected by stress.[15]

There can be little doubt that a capital trial is highly stressful and, thereby, produces a psychological reaction that alters responses to drugging. Thus, the already powerful sedative and other emotion deadening effects of the drugs may have actually been intensified during the crucial "confrontation" phase of Mr. Riggins' trial proceedings. The primary intended result of the drugging—

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15. Conditions of stress... alter the physiological state of the organism, affecting hormonal balances and central nervous system functioning. *Thus it follows that drug responses should also be altered by stress* .... That is, stimulus conditions perceived as uncomfortable or dangerous can result in individual homeostatic changes. *Stress may cause profound central and peripheral changes which are not always adaptive.* Hypoxia, hypothermia, exercise, and *psychological stress* all cause activation of the sympathetic nervous system and bring about "stress hypoglycemia", in which glucose metabolism is changed and insulin secretion inhibited by epinephrine. Since the CNS itself is not sensitive to insulin, it utilizes the available glucose. So these changes in insulin regulation and glucose metabolism underlie certain altered responses to drugs during stress.

"Drugs and Social Behavior" in *Psychoactive Drugs and Social Judgment* 25 (Hammond & Joyce, eds. 1975) (emphasis added). *See also, Handbook of Stress: Theoretical and Clinical Aspects*, at 340-45 (Goldberg & Breznitz, eds. 1983). *See also*, Cameron & Wisner, "An Anticholinergic Toxicity Reaction to Chlorpromazine Activitated by Psychological Stress," 167 *J. Nervous & Mental Disorders* 508 (1979).

Before this Court, *Amicus* and its members have long noted the impact of stress on the effects of these drugs. *See, e.g.*, Brief *amicus curiae* of the Coalition for the FREE in *Perry* v. *Louisiana*, 111 S. Ct. 449 (1990), at 12, n.9 and the Brief *amicus curiae* of the New Jersey Department of the Public Advocate in *Ake* v. *Oklahoma*, 470 U.S. 68 (1985), at 52, n. 41.

sedation—tends to defeat the Petitioner's interests in being present and involved at his own trial.

2. *The Involuntary Drugging Interfered with Petitioner's Confrontation Clause Rights*

This Court has twice recently examined the nature of the accused's right to confront his accusers in *Coy* v. *Iowa*, 487 U.S. 1012 (1988) and *Maryland* v. *Craig*, ___U.S. ___, 110 S. Ct. 3157 (1990). In both cases, the Court has rejected the view that the Confrontation Clause of the Sixth Amendment involves only a mere guarantee of the right to cross-examination.[16] As the Court noted in *Coy*; 487 U.S. at 1019:

> The thesis is on its face implausible, if only because the phrase "be confronted with the witnesses against him" is an exceedingly strange way to express a guarantee of nothing more than cross-examination.

Similarly, the Court noted in *Craig*, 110 S. Ct. at 3166:

> [W]e are mindful of the many subtle effects face-to-face confrontation may have on an adversary criminal proceeding, the presence of the other elements of confrontation—oath, cross-examination, and observation of the witness' demeanor—adequately ensures that the testimony is both reliable and subject to rigorous adversarial testing...

Clearly then, the "face-to-face" component of the confrontation is a *two*-way process—absent special considerations as in *Craig*. True confrontation necessarily involves both the face of the witness *and* that of the accused. Thus, the Court in *Coy* speaks of the difficulty of a witness lying about a person "to his face" or that a "witness' may feel quite differently when he has to repeat his story *looking at the man* whom he will harm..." *Coy*, 487 U.S. at 1019. (emphasis added)[17]

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16. *See* Dean Griswold's similar views in Griswold, "The Due Process Revolution and Confrontation," 199 *U. Pa. L. Rev.* 711 (1971).

17. These current analyses also parallel the Court's earlier expansive view of the Confrontation Clause in the context of out-of-court statements:

Implicit in all of this described interaction among witness, accused and jury is the plain-but "subtle effect" — that the witness and the jury both can observe the *accused's* reaction to his accuser. Thus, quite apart from the separate due process issues raised by the effects of the drugging on the accused (see Part III B below), here interference with confrontation arises from the fact that the drugging dulled *both* Mr. Riggins' appearance to the testifying witnesses and jury *and* "dampened," *see* n. 50 below, his reactions to the witnesses at trial.

The drugging also rendered Riggens effectively "absent" — over his objection — from the courtroom in contravention of the constitutional right to be present at one's trial.[18] The Sixth and Fourteenth Amendments guarantee a defendant the right to be present throughout his trial. *Illinois* v. *Allen*, 397 U.S. 337, 346 (1970). In *Illinois* v. *Allen*, where the defendant had disrupted his trial, this Court noted that "courts must indulge every reasonable presumption against the loss of constitutional rights," and held that a defendant may lose the right to be present only if he "insists on

> [T]he accused has an opportunity, not only of testing the recollection and sifting the conscience of the witness, but of compelling him to stand face to face with the jury that they may look at him, and judge by his demeanor upon the stand and the manner in which he gives his testimony whether he is worthy of belief. *Mattox* v. *United States*, 156 U.S. 237, 242-3 (1885)

See also Dowdell v. *United States*, 221 U.S. 325, 330 (1911) (regarding a similar clause in the Philippine Bill of Rights was intended "to secure the accused the right to be tried, so far as facts provable by witnesses are concerned, by only such witnesses as meet *him* face to face at the trial, who give their testimony in *his* presence . . .") (emphasis added).

18. Here, the defendant's absence was involuntary; the court denied his Motion to Terminate Administration of Medication after a truncated review. *Cf. Diaz* v. *United States*, 223 U.S. 442 (1912) (defendant's "voluntary" absence not grounds for finding a violation of the Confrontation Clause).

conducting himself in a manner so disorderly, disruptive and disrespectful of the court that his trial cannot be carried on with him in the courtroom." 397 U.S. at 343 (footnote omitted).

In *Illinois* v. *Allen*, this Court suggested three constitutionally permissible ways to handle an obstreperous defendant: "(1) bind and gag him, thereby keeping him present; (2) cite him for contempt; (3) take him out of the courtroom until he promises to conduct himself properly." This Court held that courts are not required to try defendants in shackles.[19]

Here, eighteen years after *Illinois* v. *Allen*, the defendant's "shackling" and "gagging" was accomplished by means of drugging rather than by the more obvious, physical means used on Allen.[20] Nonetheless, there were likely "significant feelings" related to the jury's seeing the chemically restrained

19. Trying a defendant for a crime while he sits bound and gagged before the judge and jury would to an extent comply with that part of the Sixth Amendment's purposes that accords the defendant an opportunity to confront the witnesses at the trial. But even to contemplate such a technique, much less see it, arouses a feeling that *no person should be tried while shackled and gagged except as a last resort.* Not only is it possible that the sight of shackles and gags might have a *significant effect on the jury's feelings about the defendant*, but the use of this technique is itself something of an affront to the very dignity and decorum of judicial proceedings that the judge is seeking to uphold. *Moreover, one of the defendant's primary advantages of being present at the trial, his ability to communicate with his counsel, is greatly reduced when the defendant is in a condition of total physical restraint.*

Illinois v. *Allen*, 397 U.S. at 343-344 (emphasis added).

20. Foreshadowing this case, in his opinion in *Illinois* v. *Allen*, 397 U.S. at 356-57, Justice Douglas concluded: "The case presented here . . . involves a defendant who was a sick person and who may or may not have been insane in the classical sense, but who apparently had a diseased mind." Justice Douglas noted Allen's initial finding of incompetence to stand trial and his history of mental hospitalization. *Id.* at 357, n. 5.

defendant, just as the Court predicted in the "visible restraint" situation described in *Illinois*. It is no exaggeration that Mellaril and other similar psychotropic drugs are commonly referred to as "chemical restraints" — and worse.[21]

Applying *Illinois* v. *Allen* to the case at hand, it is clear that the Petitioner here is entitled to the reasonable presumption against the loss of his constitutional right to be present at his trial, without any restraints, either physical or chemical in nature. *In Illinois* v. *Allen*, 397 U.S. at 341, 342, Allen had repeatedly and purportedly deliberately attempted to disrupt the proceedings against him. Here, Riggins never had the opportunity to appear in court in his natural, unmedicated state; he was chemically restrained throughout the trial. Thus, there is no evidence that he was disruptive. There is only a pair of half-hearted predictions of possible deterioration and obstruction by one psychiatrist who testified at trial. R. 753, 762. Speculation alone is clearly an inadequate basis to justify depriving petitioner of his right to be present at his trial and to confront the witnesses against him. Moreover, this is hardly an adequate explanation to the jury for denial of Petitioner's right to confrontation. Further, Mr. Riggins' mental illness was not typically characterized by loud or disruptive behavior. R. 595, 653, 656.

The Sixth Amendment surely includes the right to freely interact with one's counsel during the testimony of adverse witnesses. In *Maryland* v. *Craig*, this Court specifically noted the importance of this subtle aspect of confrontation, the right to interact with one's

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21. See Sovner, "Behavioral Psychopharmacology Update" 9 *Habilitative Mental Healthcare Newsletter* 34, 35 (1990) ("chemical restraint (*the way thioridazine [Mellaril] is*") (emphasis added). *See also*, Horton "Restoration of Competency for Execution: *Furiosus Solo Furore Punitur*," 44 *Sw. L.J.* 1191, 1204 (1990) (psychotropic drugs described as "a chemical straitjacket") *See, e.g.*, Ferleger "Loosing the Chains: In-Hospital Civil Liberties of Mental Patients," 13 *Santa Clara Law.* 447 (1973); Plotkin & Riging, "Invisible Manacles: Drugging mentally retarded people." 31 *Stanford L. Rev.* 637 (1979).

lawyer during the trial.[22] In holding that testimony by closed circuit television by a child may be permissible, this Court noted that the "defendant retains full opportunity for contemporaneous cross-examination." 110 S. Ct. at 3166.[23] In *Craig*, the defendant remained in electronic communication with his attorney, and was thus able to assist in cross-examination. 110 S. Ct. at 3161. As part of the Confrontation Clause requirement that the defense be given a full and fair opportunity to probe and expose testimonial infirmities, 110 S. Ct. at 3164, defendant must have the opportunity to communicate with his attorney throughout the trial. If a defendant is sedated as a result of forced drugging, it may be impossible for him to be alert during the trial and therefore he may be unable to consult with his attorney during the examination of witnesses. Surely, given the soporific effects of Mellaril, drugging Mr. Riggins with a high dose of Mellaril during trial was, in effect, "placing a sustained barrier to communicate between ... defendant and his lawyer." *Geders* v. *United States*, 425 U.S. 80, 91 (1976); *cf. Perry* v. *Leeke*, 468 U.S. 272 (1989).

The Confrontation Clause also involves the defendant's observation of the *witnesses'* demeanor and his reactions to their cross-examination. *California* v. *Green*, 399 U.S. 149, 158 (1970).[24]

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22. Earlier, in *Coy*, it is not clear from the opinion where the defendant's counsel was positioned relative to the "large screen . . . placed between appellant and the witness stand . . ." *Coy* v. *Iowa*, 487 U.S. at 104. However, the Iowa statute specifically addressed the issue: "[T]he court shall take measures to insure that the party and counsel can confer during the testimony . . ." Iowa Code §910A.14 (1987)). Nonetheless, this Court found that the use of a screen violated the defendant's rights under the Confrontation Clause. *Coy*, 487 U.S. at 1022.

23. *Craig* itself has been criticized for not dealing adequately enough with the interference to communication with counsel under the Maryland television scheme. *See, e.g.*, Schwalb, "Child Abuse Trials and the Confrontation of Traumatized Witnesses: Defining 'Confrontation' to Protect Both Children and Defendants," 26 *Harv. Civ. Rights & Civ. Liberties L. Rev.* 189, 202-204 (1991).

24. One possible source for the Confrontation Clause is in the 1696 trial of Sir John Fenwick. There, the court stated:

Here, Mr. Riggins was not able to react normally to the witnesses' testimony because of the sedating influence of Mellaril. Here we, too, as Justice Scalia noted in *Coy*, have no way of knowing "whether the witnesses' testimony would have been unchanged, or the jury's assessment unaltered ..." *Coy* v. *Iowa*, 108 S. Ct. at 2803. The Petitioner's drugged "presence," much like his total absence or actual physical shackling and gagging, unalterably skewed the reactions of the other participants in the trial process.

B. There Was No Constitutional Justification for Involuntarily Drugging Petitioner During Trial

1. *Because of the Powerful and Potentially Dangerous Side Effects of These Drugs, Petitioner Should Have Been Given Every Opportunity to Avoid Being Drugged At Trial.*

When the trial judge denied Petitioner's Motion to Terminate Administration of Medication, he permitted continuation of psychotropic drugging that was fraught with peril for Riggins. All the most current research on Mellaril confirms that even "low" doses of this drug are capable of causing irreversible harm and a wide variety of bodily organic and systemic effects including cardiac,[25]

> "Our law requires persons to appear and give their testimony 'viva voce'; and we see that their testimony appears credible or not by their very countenances and the manner of their delivery; and their falsity may sometimes be discovered by questions that *the party may ask them* . . ." Proceedings Against Sir John Fenwick, 13 How. St. Tr. 537, 591-92 638 (1696) in 5 *The Founders' Constitution* 247 (Kurland & Lerner 1987).

Note, "Eighth Circuit Applies the Confrontation Clause at a Sentencing Hearing," 17 *Wm. Mitchell L. Rev.* 829, 832-3, n.16 (1990) (emphasis added).

25. Wilens & Stern, "Ventricular Tachycardia Associated with Desipramine and Thioridazine," 31 *Psychosomatics* 100 (1990).

renal,[26] vision,[27] excretory,[28] and other dysfunctions, as well as disabling conditions, such as tardive dyskinesia, dystonia, and, neuroleptic malignant syndrome.[29] This newer research merely confirms what has been known about the drug's side effects almost since the first introduction and adoption of Mellaril in 1959 as a symptom suppressing agent.[30]

Current research demonstrates that by themselves, even low dosages and short terms of Mellaril treatment or even drug treatment withdrawal are no protection from the risks of serious disabling, even disfiguring and stigmatizing side effects.[31] Lest these

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26. Urberg, "Thioridazine-Induced Non-Icteric Hepatotoxicity," 30 *J. Fam. Prac.* 342 (1990).

27. Ball & Caroff, "Retinopathy, Tardive Dyskinesia and Thioridazine," 143 *Am. J. Psych.* 256 (1986).

28. Ananth & Lin, "SIADH: A Serious Side Effect of Psychotropic Drugs," 16 *Int'l J. Psych. Med.* 401 (1987) .

29. Zammit & Sullivan, "Thioridazine and Neuroleptic Malignant Syndrome," 22 *Biol. Psych.* 1296 (1987) (letter); Moore, MacFarlane & Blumhardt, "Neuroleptic Malignant Syndrome," 53 *J. of Neurology, Neurosurgery, & Psych.* 517 (1990)

30. *See, e.g.* Kelly, Fay & Laverty, "Thioridazine Hydrochloride (Mellaril): Its Effect on the Electrocardiogram and a Report of Two Fatalities with Electrocardiographic Abnormalities," 89 *Can. Med. A.J.* 546 (1963). *But see* Wendkos,"Thioridazine and Electrocardiographic Abnormalities," 89 *Can. Med. A.J.* 1297 (1963). For other early warnings about this drug, *see also* Barancik, Brandborg & Albion,"Thioridazine-Induced Cholestosis," 200 *JAMA* 69 (1967); Davidorf, Thioridazine Pigmentary Retinopathy," 90 *Arch. Opthalmol.* 251 (1973); Kotin, Wilberg, Verbert & Solinger,"Thioridazine and Sexual Dysfunction," 133 *Am. J. Psych.* 82 (1976); Haberman, "Malignant Hypothermia: An Allergic Reaction to Thioridazine Therapy," 138 *Arch. Internal Med.* 800 (1978); Hussain & Murphy,"Thioridazine-induced toxic psychosis," 104 *Can Med. A.J.* 884 (1971); Rothstein,"Allergic Reactions to Thioridazine," 290 *N. Eng. J. Med.* 521 (1974); Gonzalez,"Disadvantages of Prescribing Thioridazine," 138 *Am. J. Psych.* 1131 (1981)

31. *See* Giron, "Tardive Dystonia after a short course of Thioridazine," 34 *J. Fam. Prac.* 405 (1987); Koschlo, Dolor & Lipper, "Delayed Onset of Neuroleptic Malignant Syndrome after Discontinuation of Thioridazine," 10 *J. Clinical Psychopharmacology* 146 (1990), Hitri, Carter,

aspects of Mellaril appear to be idiosyncratic to this drug, they only differ slightly in kind or degree from the effects equally well known and documented side of the other phenothiazine drugs of the same "family" as Mellaril.[32] Indeed, it is *just* these disabling, stigmatizing side effects and questions about efficacy[33] that have resulted in the widespread demand for access to newer, alternative drugs by mental health consumers, their families and advocates.[34]

Shoh, Borison & Diamond, "Neuroleptic Blood Levels and Tardive Dyskinesia," in *Chronic Treatments in Neuropsychiatry* (1985).

32. *See, e.g.*, Alexander, "Cardiotoxic Effects of Phenothiazine and Related Drugs," 38 *Circulation* 1014 (1968); Leetsma & Koening "Sudden Death and Phenothiazine," 18 *Arch. Gen. Psych.* 137, 147 (1968) ("Recent experimental work indicates that the phenothizines (Thioridazine and to a lesser extent Chlorpromazine) have many potent and often unpredictable actions on the cardiovascular system, that many of the cases of sudden unexplained deaths have apparently died cardiovascular deaths ... The authors feel there is a real entity of sudden death caused by phenothizines").

33. One researcher cautioned those administering these drugs:

> After decades of pharmocokinetic and pharmacodynamic research, the therapeutic outcome of neuroleptic treatment *is still largely unpredictable in the individual* case. While most patients respond rapidly to carefully controlled and individually adjusted dose and serum drug concentrations, some require considerably longer treatment periods for complete recovery and others improve only partially or not at all. A symptom that is efficiently erased in one patient may thus resist optimal treatment with the same neuroleptic drug in another case.

Axelsson & Ohman, "Patterns of response to neuroleptic treatment: Factors influencing the amelioration of individual symptoms in psychotic patients," 76 *Acta Psych. Scand.* 107 (1987)

34. *See, e.g.* Blackburn, "New Directions in Mental Health Advocacy? Clozapine and the Right of Medical Self- Determination" 14 *ABA Mental & Physical Disability L. Rep.* 453 (1990); Green & Salzman "Clozapine: Benefits and Risks," 41 *Hospital & Community Psych.* 379 (1990); Winslow, "Courts Consider Schizophrenia Drugs Access," *Wall St. J.*, B1 (Oct. 5, 1990).

2. *Any "Balancing" of Interests Here Favors Petitioner's Interest in Not Being Involuntarily Drugged at Trial*

In this Court's recent opinion on forced drugging of prisoners, *Washington* v. *Harper*, 494 U.S. 210 (1990), this Court applied a balancing test and balanced the prisoner's liberty interest in not being drugged as against the state's interest in combating the danger posed to himself and others by a violent, mentally ill inmate under the "reasonable relation" test of *Turner* v. *Salfey*, 483 U.S. 78 (1987). The Court held:

> We hold that, given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, *if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.*

494 U.S. at 225-27 (emphasis added, citations omitted). Here, there was no evidence that Riggins was dangerous to himself or others at the time of trial. Therefore, Riggins' liberty interest in not being drugged outweighs the State's interest in drugging him.

Given the foregoing analyses of the known, intended effects of Mellaril (Part III A) as well as the unintended, "side" effects of the drug (Part III B 1), in order to justify drugging there must first be at least a showing that Mr. Riggins' "medical treatment needs" required the drugging. As one leading federal court noted, however:

> Medical treatment is designed to ensure that the condition of pretrial detention does not amount to the imposition of punishment. This constitutional requirement cannot be turned on its head to mean that if a competent individual chooses not to undertake the rules and pain of *potentially dangerous* treatment, the jail may force him to accept it. ... [A]lthough the state undoubtedly has *an interest in bringing to trial those accused of a crime*, we question whether this interest could ever be deemed sufficiently compelling to outweigh a

> criminal defendant's interest in not being forcibly medicated with antipsychotic drugs.... Bee does not dispute that forcible medication with antipsychotic drugs may be required in an emergency. *Absent an emergency*, we do not believe forcible medication with antipsychotic drugs is "reasonably related" to the concededly legitimate goals of jail safety and security. *Bee* v. *Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984) *cert. denied*, 469 U.S. 1214 (1985) (emphasis added).

See also, Large v. *Superior*, 714 P.2d 399, 408 (Ariz. 1986) ("forcible medication with dangerous drugs should be limited to specific emergencies under procedural safeguards").

The apparently conflicting opinion in *United States* v. *Charters, 863 F.2d 302 (4th Cir. 1988) (en banc), cert. denied*, 110 S. Ct. 1317 (1990), simply does not control a case such as that presented here. First — and foremost — Charters was *not* medicated at the time of the elaborate review process outlined in *Charters*, 863 F.2d at 304, 305,[35] whereas here Riggins was medicated even *before* the inverted, post-hoc judicial hearing on the drugging. Because of his ongoing drugging, there was simply no evidentiary basis — other than pure psychiatric speculation — for finding that Riggins was potentially incompetent or disruptive, or in any other disabling or dangerous condition *without* a termination of his drugging. Indeed, Dr. Quass, the only psychiatrist to see Riggins in an undrugged condition, testified that he was competent without the drugging. R. 443, 449-50. That fact alone should have justified granting Riggins' Motion to Terminate Administration of Medication.

Without that "drug holiday," the trial court turned *Charters* on its head by holding its hearing *after* the drugging, and its intended

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35. *See also Application for a Stay in Charters* v. *United States, stay granted*, (A. 88-628) 57 U.S.L.W. 3545 (U.S. Feb. 14, 1989), at 1 and Petition for Certiorari (No. 88-6525) (Mar. 5, 1990) in *Charters* v. *United States, cert. denied*, 110 S. Ct. 1317 (1990).

sedation and other effects, were already taking place. Nothing in *Charters* justifies that bizarre result. Indeed, none of the leading cases and authorities on the proposition seem to countenance allowing the drugging to proceed *before* whatever process is due. *See In re Pray*, 133 Vt. 253, 336 A.2d 174, 177 (1975) ("In fact, it may well have been necessary... to expose the jury to the undrugged, unsedated [defendant] at least insofar as safety and trial progress might permit"); *State* v. *Maryott*, 6 Wash. App. 96, 492 P.2d 239, 243 (1971) ("[N]o control should be imposed until its need has been demonstrated....").

Thus, there is simply no authority in *Harper, Charters* or *Bee* or any of the leading state cases for the inverted, post hoc procedure followed here. None of the psychiatric predictions of dangerousness[36] — prophesies of "doom in the courtroom" — can justify the continued drugging over Mr. Riggins' desire to proceed unmedicated, particularly in this truly life or death setting.[37] As this Court noted in *Gardner* v. *Florida*, 430 U.S. 349, 357 (1977) "death is a different kind of punishment from any other which may be imposed in this country."

The insanity defense imposes a unique set of different issues on trials, courts and advocates involved in cases where it has been raised.[38] With both "different" aspects involved here, the balancing of Riggins' interest in not being medicated during his capital trial

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36. *See*, as to the imprecision of such predictions, Ennis & Litwack, "Psychiatry and the Presumption of Expertise," Flipping Coins in the Courtroom," 62 *Calif. L. Rev.* 693 (1974); Slobogin, "Dangerousness and Expertise" 133 *U. Pa. L. Rev.* 97 (1984).

37. *See* Part III A above, regarding the need for a justification for restraint under *Illinois* v. *Allen*; Poythress & Stoch, "Competency to Stand Trial: A Historical Review and Some New Data," 8 *J. Psych. & L.* 131 (1980).

38. *See, e.g.*, Perlin, "Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence," 40 *Case W. Res. L. Rev.* 599, 721 (1990).

surely takes on some of the characteristics as well of *Perry* v. *Louisiana*, U.S. , 111 S. Ct. 449 (1990), last Term's death row "right to refuse" case.[39] Here, as in *Perry*, the State's interest in drugging Riggins—is hardly a truly "healthy" interest in his long-term welfare. Here the State's current interest in Riggins is but one level removed from Louisiana's fatal "interest" in *Perry*. If Riggins' conviction and sentencing while being drugged withstands this appeal, the ultimate issue will then become that of drugging on death row, as in *Perry*.

The balancing here seems just as clear as in *Perry:* there can be no continuation of drugging without a proper justification of medical necessity. In *Harper* that justification turned on "whether the inmate suffers from a "mental disorder"; and second, whether, as a result of that disorder, he is dangerous to himself, others or their property." *Harper*, 110 S. Ct. at 1042. Here, before trial there was no proof of *any* current propensity toward dangerousness[40] and little, if any, evidence of any current mental disorder other than some-months-old past history. Using the *Harper* analysis therefore,

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39. On remand, *Perry* v. *Louisiana* has recently been granted review by the Supreme Court of Louisiana, where again the issue is whether the State's interest in executing him overrides his right to refuse. "The State has admitted in this case that the sole purpose of seeking to medicate Michael is to execute him." Original Application on Behalf of Michael Owen Perry, *State of Louisiana* v. *Michael Owen Perry*, (La. Sup. Ct., June 10, 1991), (No. 91KP1324) at 25; *rev. granted*, (Sept. 20, 1991). Argument has been scheduled for Dec. 5, 1991.

40. For once, all of the usual sly suggestions by prosecutors of defendant's possibly "faking" mental illness turn against the State in this context. *See, e.g.*, R. 724. If Mr. Riggins were "faking" mental illness, then he stood a better chance of being detected if he had *not* been receiving large doses of Mellaril. *See, generally:* Perlin, *supra n.* 38, 40 *Case W. Res. L. Rev.* at 713-720. *See also*, for some background on similar claims of "faking," Geller, Erlen, Kaye & Fisher, "Feigned Insanity in Ninteenth-Century America: Tactics, Trials and Truth," 8 *Beh. Sci. & L.* 3 (1990)

in the absence of any proof of current mental illness[41] and of dangerous acts, Mr. Riggins should have been permitted to "Just Say 'No'" and then been allowed to proceed to trial without the drugging he sought to refuse. Only if trial were demonstrated not to be possible without disruption, could the trial court then proceed with its analysis under *Illinois* v. *Allen*.[42]

In *Washington* v. *Harper*, this Court made clear that "some kind of hearing" on the issue was due before even a *convicted and sentenced* prisoner was forcibly drugged with psychotropic medication. 494 U.S. at 228. The guiding standard to be applied in such process required under *Harper* was whether the prisoner was a danger to himself or others in the prison setting. That holding was consistent with the Court's earlier holding touching on this issue in *Vitek* v. *Jones*, 445 U.S. 480 (1980)[43] and with other courts that have

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41. *See, generally*, Fentiman, "Whose Right Is It Anyway? Rethinking Competence to Stand Trial In Light of the Synthetically Sane Insanity Defendant," 40 *U. Miami L. Rev.* 1109,1165 (1986)

42. *See also Jones* v. *United States* 463 U.S. 387 (1983) (Brennan, J. dissenting):

> Administration of psychotropic medication to control behavior is common. Although this Court has never approved the practice, it is possible that an inmate will be given medication for reasons that have more to do with the needs of the institution than with individualized therapy. *See Mills* v. *Rogers*, 457 U.S. 291, 303, 102 S.Ct. 2442, 2450, 73 L.Ed. 2d 16 (1982); *Rennie* v. *Klein*, 653 F.2d 836, 845 (3d Cir. 1981) *en banc*.

43. *Vitek* actually involved the attempted administration of Thorazine as part of a behavior management program. *See Vitek*, 445 U.S. at 493-94:

> A criminal conviction and sentence of imprisonment exinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to subject him to *involuntary psychiatric treatment* without affording him additional due process protection. (Emphasis added.)

While *Vitek* was decided two years before *Mills* v. *Rogers* and *Rennie* v. *Klein* reached this Court, the briefs and the transcript of the oral argument before this Court in *Vitek* demonstrate that forced drugging was a subtext

addressed the issue of forced drugging in similar contexts. *See, e.g., United States* v. *Watson*, 893 F.2d 970, 982 (8th Cir. 1990).[44]

Because of *Harper, Vitek* and the other precedents applying due process to *convicted and sentenced* prisoners, it is clear that *a fortiori* at least equivalent — if not, *additional* — procedures should be required in the context of a *pre-trial* defendant. Indeed, the few federal court opinions in this issue support a careful "right to refuse" judicial review procedure. *See, e.g., Bee* v. *Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985). *See also United States* v. *Charters*, 863 F.2d 302, 313 (4th Cir. 1988), *cert. denied*, 110 S. Ct. 1317 (1990). In this case, however, the trial court's hurried review of the Petitioner's need for the medication, R. 438, failed to meet the standard set by this Court in *Harper*.[45]

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in that case. *See, e.g.*, Brief of Appellee, Larry D. Jones, at 7 ("when such transfer will submit him to chemotherapy"); at 16 ("Once transferred he was forced to take Thorazine, his prescribed medication. When he refused, he was injected with the medication..."); at 20 (regarding "the common use of chemotherapy in mental hospitals" as a danger to transferred prisoners); and Transcript of Oral Argument, Dec. 5, 1979, at 19-20 (prisoner's "right to refuse" medical treatments).

44. In *Watson*, 893 F.2d at 972 the court held that Holmes, one of the two prisoners, could not be medicated against his will without additional due process ("No such hearing has been held with respect to Holmes. No interest would be served in speculating as to whether Holmes presents a danger to his community at this time. We simply hold that if Holmes is presently functioning adequately in the prison setting and does not present a danger to himself, other inmates, or prison staff, the government may not forcibly administer antipsychotic medications").

45. In *Winston* v. *Lee*, 470 U.S. 766, (1985) this Court barred a minimal surgical procedure to obtain evidence, holding: "The medical risks of the operation, although apparently not extremely severe, are a subject of considerable dispute; the very uncertainty mitigates against finding the operation to be 'reasonable.'" Here, similarly, the dispute over the drugs and their effects is longstanding and ongoing. *See* Parts III A and B above. *See Harper*, 494 U.S. at 226. "There is considerable debate over the potential side effects of antipsychotic medications...." *See also Harper* 494 U.S. at 229 "[I]t is also true that the drugs can have serious, even fatal side effects."

C. Forced Drugging Interfered with Petitioner's Right to Present an Insanity Defense Because The Jury Was Unable To See His Natural Demeanor and Instead Medication Rendered His Demeanor Sedated and Emotionless

The principal issue at trial was Petitioner's defense that he was insane at the time of the crime. There was no evidence that Petitioner was on antipsychotic medication at the time of the crime. At trial he was drugged with medication known and intended to sedate him and deaden his emotions. The drugging interfered with his right to present his own defense, by altering both Mr. Riggins' demeanor and behavior before the court and resulting in the presentation of misleading evidence that totally undermined his insanity defense before the jury.

Demeanor is particularly important in an insanity defense. Courts have universally recognized that, when sanity is at issue, demeanor is of probative value to the trier of fact, which was the jury in this case. *See, e.g., Commonwealth* v. *Louraine*, 398 Mass. 28, 453 N.E.2d 437, 442 (1983). Thus, in *State* v. *Maryott*, 6 Wash. App. 96, 492 P.2d 239 at 242, the court, "When mental competence is at issue, the right to testimony involves more than mere verbalization." The Massachusetts Supreme Court explained the importance of demeanor testimony and the effects of drugging:

> if the defendant appears calm and controlled at trial, the jury may well discount any testimony that the defendant lacked, at the time of the crime substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law. This tendency may render also valueless the defendant's right to testify on his own behalf.

453 N.E.2d at 442 (citations omitted).[46]

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46. *See also State* v. *Maryott*:

> If the state may administer tranquilizers to a defendant who objects, the state then is, in effect, permitted to determine what the

There can be little dispute that what the jury saw of Petitioner in this case was not what the jury heard about from the various witnesses. Instead of a person demonstrably suffering from a major mental illness, *see* Part III A above, as repeatedly described to them, R. 534-35, 711-15, 747, 753, 765, 964-66, what the jury in fact saw here was someone who earlier had been nodding off in court. R. 429-30, 432.

The vital importance of demeanor testimony was demonstrated in a recent study of jurors in death penalty cases.[47] The juror who attached the most significance to a defendant's demeanor in this study described his demeanor at trial as callous and indifferent.[48] In another capital case investigated by this study, jurors influenced by the defendant's demeanor described him as "indifferent to the proceedings" "passive" "emotionless" "no remorse — no anything."[49]

> jury will see or not see of the defendant's case by medically altering the attitude, appearance and demeanor of the defendant, when they are relevant to the jury's consideration of his mental condition.

492 P.2d at 242.

47. Geimer & Amsterdam, "Why Jurors Vote Life or Death: Operative Factors in Ten Florida Death Penalty Cases," 15 *Am. J. Crim. L.* 1 (1987-88). About one-third of the jurors interviewed said that the defendant's demeanor was a contributing factor in the sentence recommendation, and one juror attributed the verdict entirely to the defendant's demeanor. *Id.* at 51.

48. She said, "Nobody saw a heartbeat of regret. He didn't move a muscle except for crossing his legs. By the time of the penalty phase, the jury was not inclined to feel sorry for him. Minds were already colored." *Id.* at 52.

49. *Id.* at 52.

Passiveness, indifference, and lack of emotion on the part of a defendant are clearly influential in a jury's determination. The scientific literature, discussed *supra*, confirms that Mellaril, especially at the 800 mg. dosage that Petitioner was receiving at trial, has the effect of sedation and flattening of affect and emotional passivity. In this case, Mellaril had the effect of sedating petitioner and flattening petitioner's affect and making him emotionally passive at trial.[50] The real gravamen of Petitioner's argument on the issues of evidence and presumption of innocence is that, by presenting him at trial in such a heavily drugged condition, the State improperly benefitted from making him "look" guilty and unremorseful to the jury, while not permitting him to present freely his own most effective evidence and argument as to the key issue of his mental condition in contradiction of this Court's holdings in such cases as

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50. There is substantial evidence that Mellaril and other related drugs affect intellectual function. Thus, the immediate past administrator of the National Institute of Mental Health has said:

> The findings of this study were ... chronic schizophrenics on thioridazine when compared to placebo subjects showed a definite *dampening* of peripheral indicators of automatic reactivity. In addition, there was a significant reduction to the number of remote and bizarre associations to the word association test in the drug group and an increase in the placebo group. Also, the schizophrenic on drugs showed much less avoidance of threatening verbal stimuli in the perceptual defense battery than did those subjects on placebo.

Judd, Goldstein, Rodnich & Jackson, "Acute Schizophrenia and Phenothiazine" in *Psychopharmacology and the Individual Patient* 83 (1970) (emphasis added). Researchers who have argued that the drugs have no effect on intellectual functioning and cognition have not focused on the issues of sedation and lack of affect. *See, e.g.*, Gutheil & Applebaum, "'Mind Control', 'Synthetic Sanity', 'Artificial Competence' and Genuine Confusion: Legally Relevant Effect of Antipsychotic Medication, 12 *Hofstra L. Rev.*, 77, 91, 203 (1983) (focusing primarily on studies of "the effects of medication on memory, learning and cognition" rather than sedative effects which are barely even addressed).

Morrisette v. *United States*, 342 U.S. 246, 275 (1952) ("(T)his [conclusive] presumption would conflict with the overriding presumption of innocence which the law endures the accused and which extends *to every element* of the crime") (emphasis added). *See also*, *Sandstrom* v. *Montana*, 442 U.S. 510, 520-523 (1979). By altering Petitioner's demeanor and behavior by drugging him at trial, the State undercut both the presumption *and* improperly shifted its burden of proving the requisite mental element for the crime. *Cf. Sandstrom*, 442 U.S. at 524; *Medina* v. *California*, *cert. granted*, 60 U.S.L.W. 3330 (U.S. Oct. 21, 1991) (No. 90-8370).

Studies suggest that evidence actually put on "live" before the jury has a much more persuasive effect than mere expert testimony or other similar "cold" presentation.[51] In the language of social science, this is the so-called "vividness" effect.[52] More colloquially, seeing is believing. Studies of vividness demonstrate how the drugging hampered Mr. Riggins in the critical task of persuading the

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51. *See, e.g.*, Bell & Loftus, "Vivid Persuasion in the Courtroom", 49 *J. Personality Assessment* 659 (1985) "One quality of information that determines its persuasive impact is its vividness. Information can be characterized as vivid to the extent it is '(a) emotionally interesting, (b) concrete and imagery-provoking and (c) proximate in a sensory, temporal or spatial way" (quoting from Nesbett and Ross *Human inference, strategies and shortcomings of social judgment* (1980); Saks and Kidd, "Human Information Processing and Adjudication: Trial by Heuristics," *Law & Soc. Rev.* 121, 138 (1980-1) ("[W]e would predict that the quantitative data of the sociologist would have been *less* persuasive [at trial] than the anthropologist' anecdotal report, because the latter would generally be more concrete and salient, and therefore more accessible").

52. Taylor & Thompson, "Stalking the Elusive 'Vividness' Effect," 89 *Psych. Rev.* 155 (1982) *See also* Shedler & Manus, "Can the Availability Heuristic Explain Vividness Effects?" 51 *J. Personality and Soc. Psych.* 2635 (1986) ("Vividness affected (a) our respondents' recall of material that had previously been presented and (b) their subsequent judgments."); Reyes, Thompson and Bower, "Judgmental Biases Resulting from Differing Availabilities of Arguments," 36 *J. Personality & Soc. Psych.* 2 (1980).

jury that he was not guilty because he was insane at the time of the crime. Just as with "vividness" generally, the great body of authority on the issue of the insanity defense confirms that juries need to be "shown" rather then just told about the defendant's mental illness. In general, public reactions to mental illness are known to be negative[53] and disbelieving and, in particular, there is a wealth of research showing skepticism to, if not outright rejection of, the insanity defense.[54] Given that pre-existing resistance to the fact of mental illness and the claim of exculpation on that basis, there is a particular need for every bit of persuasive "vivid" evidence in such cases.[55]

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53. It is particularly disturbing that this negative attitude continues despite all of the evidence to the contrary. *See, e.g.*, National Institute of Mental Health, *Schizophrenia: Questions and Answers*, (Pamphlet, 1986) at 6:

> Although news and entertainment media tend to link mental illness and criminal violence, studies tell us that if we set aside those persons with a record of criminal violence before hospitalization, mentally ill persons as a whole are probably no more prone to criminal violence than the general public. Certainly most schizophrenic individuals are not violent; more typically, they prefer to withdraw and be left alone.

54. *See, e.g.*, Perlin *supra*, n. 38, 40 *Case W.L. Rev.* at 728 ("The public's hostility to mental illness and the mentally disabled offender arises from a complex combination of sources...") *See also* Friedman, "The Concept of Self in Legal Culture," 38 *Clev. St. L.R.* 517, 528 (1990) ("The insanity defense looked to many people like a loophole....").

55. *See, e.g.*, Fentiman "Whose Right Is It Anyway? Rethinking Competence to Stand Trial in Light of the Synthetically Sane Insanity Defendant," 40 *U. Miami L. Rev.*, 1109 (1986). In *Commonwealth* v. *Louraine*, 398 Mass. 28, 453 N.E.2d. 437, 442 (1983), the court held that, "The ability to present expert testimony describing the effect of medication on the defendant is not an adequate substitute." The court explained:

> At best, such testimony would serve only to mitigate the unfair prejudice which may accrue to the defendant as a consequence of his controlled outward appearance. It cannot compensate for the positive value to the defendant's case of his own demeanor in an unmedicated condition. *Id.*

Here the result of Mr. Riggins' drugging was the very antithesis of "vividness," the drugging — as it is intended to do — produced a narrowed range of emotional responses and reactive behavior. *See, e.g.*, the research studies regarding the effects of Mellaril, Part III A. Like Sherlock Holmes' famous dog that did *not* bark,[56] perhaps the best evidence here that Mr. Riggins was not himself at trial is that there is so little commentary in the record on his behavior or reaction during trial. *See* State of Nevada's Brief in Opposition to the Petition for Writ of Certiorari, at 17.

The drugging's creation of a defendant who was "present" in body, yet "absent" in vital elements of his personality and mental activity, renders the judgment below constitutionally infirm.

56. "Silver Blaze" in Doyle, *The Complete Sherlock Holmes* (1970).

CONCLUSION

For the reasons stated herein, *amicus curiae* Coalition for the FREE respectfully urges this Court to reverse the judgment below.

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